A clarification on the use of the term "compliance"

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TO THE EDITOR: There exists today a rather common usage, in terms of some international scientific literature on psychology or clinical psychiatry, of the concept of "compliance". To my mind, this usage is not only incorrect but also non-beneficial to practitioners in both the research and clinical fields. I thus feel it necessary to clarify the matter.

The term compliance has its roots in pharmacological research: originally it referred to a patient's observance of pharmacological prescriptions – his/her willingness to take the medications prescribed by the treating doctor, and also to accept the general conditions of dosage, procedure, and times of intake, regardless of the possible onset of side effects. Subsequently the meaning of the term was extended to include a patient's observance of non-pharmacological aspects of treatment, those that concern diet, life-style, periodical check-ups etc. (In current medical literature the term "adherence" is often used as a synonym of compliance).

In time, the term compliance was adopted in areas related to cognitive behavioural therapy (CBT). Why did cognitive-behavioural psychologists begin to use this term? The answer lies within the absence of suitable vocabulary for describing a patient's adherence to prescribed psychotherapeutic recommendations. CBT psychologists could have chosen more appropriate linguistic expressions, but perhaps out of the fear of losing their own theoretical and clinical identity, they preferred not to resort to the classical terminology of dynamic psychology. The concept of compliance hence acquired a clinical significance (from Greek *klinē*; implying a personalized and unique relationship between patient and doctor).

As is well-known, non-compliance, or non-adherence, is among those factors that can most compromise the clinical effectiveness of therapies. The difficulty is that the available research on compliance has limited usefulness for clinical practice (that is not what is required of it) Undoubtedly of greater value is the work on the therapeutic alliance, or the working alliance between physician and patient, representing the other side, the clinical side, of compliance.

The therapeutic alliance is an operational concept that embodies a process, an evolution — a bond built over time that goes through the normal break-ups and repairs that occur within the diagnostic/therapeutic course of treatment, and on which the clinician works together with the patient. This partnership is thus the result of a process of continuous negotiation between the therapist and the patient, in which the subconscious dynamics of the pair have great importance.

The quality of the doctor-patient relationship depends largely on the quality of their communication. It is the clinician's job to facilitate the progress of communication. Out of this interaction there may arise a whole set of individual, family, and environmental variables that can affect and influence the therapeutic alliance – goals and aims, expectations, perplexities, setbacks, and anxieties over the therapeutic project, as well as a possible mistrust of and/or impatience with the doctor. All this can lead to theories and ideas on the illness, reasons behind the cure, and newly-acquired perceptions of the family and social support. Throughout this, the doctor keeps the patient abreast of the technical aspects of the therapy, providing information on the nature of the illness or disorder afflicting him/her, explaining the usefulness and necessity of therapy, reassuring him/her that all difficulties will be considered and discussed together. Compliance therefore comes from a good therapeutic alliance, from the quality of the therapeutic relationship that the doctor is able to establish with the patient, and is the result of a multi-dimensional process, in which the focus cannot only be on "which" therapy to prescribe, but must also be on "how" to prescribe it.

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